CALIFORNIA DEPARTMENT OF Mental Health

2011 COMMUNITY MENTAL HEALTH SUMMER STAKEHOLDER SERIES
DATE: August 26, 2011 LOCATION: San Bernardino, CA

Participants

31	Consumers/Family Members/Consumer Advocates
30	Providers
30	County Representatives
01	Phone Participants
92	**Total Participants**

Pre-Meeting Education Session- Questions/Comments

- Regarding WET, we are talking about preparing people to go into MH system. Correct? What about pre-employment training for consumers? Working well Together is a contract program that does some employment preparation for consumers. This is not however, a current function of the State DMH.
- Caregiver Resource Centers can go to the Dept. of Aging
- What will happen after the stakeholder process? Who will be making the final decisions about where the functions will go? DMH will prepare a summary of stakeholder input and forward it to Legislature
- ADP and DMH do not translate or cross-over, there is a different language. We don't want to be under an agency that requires that criteria are met before services are offered. It is disheartening that so much has been taken away. "The fox isn't guarding the hen house."
- Applaud the county for having AOD under Behavioral Health. Are you thinking about health services as you move closer to health care reform in 2014?

Background and Context Questions/Comments

- Do the local entities have the resources to cover the functions? The budget discussions have not happened about shifting [resources] from the State to Local. If shifting to another State agency, funding will follow.
- How will all of this help w/ housing, businesses, and the economy.
- Executive leadership is important. The designated staff does not include Executive leadership. Where are these positions? The current structure is that a CEA level (Exec manager) and other managers report to the CEA
- The mental health leadership needs to have subject matter expertise. The Director of DHCS is committed to ensuring that the leadership for mental health / Alcohol and drug Programs is a subject matter expert (SME) DMH staff who have expertise will follow MH Medi-Cal functions to DHCS. The 19 positions are all SME's.
- What is DMH currently thinking? There are four options:
    1. Move all functions to DHCS
    2. Create a joint DMH/ADP agency

Please note: Stakeholder questions appear in black font, DMH response indicated in red font.

3. Stand alone mental health dept.
4. Move functions to appropriate other state or local entities

- Do we still have a chance to influence the decision-making? Yes, these meetings will make up the DMH summary report that will be forwarded to legislature for consideration. We will share info on September 16th through a webinar on-going stakeholder meeting monthly through July.
- What about services for homeless? If the state should be doing more let us know in the break-outs.
- Are we only talking about the 19 positions and functions? The Medi-Cal staff/functions are going to DHCS. If you don't think 19 staff is enough, let us know that too.

Based upon today's presentation, what are the changes in mental health at the state level that stand out for you?

- It is better to have one system of care. Having the functions/funding broken up could cause more problems (e.g. reporting to multiple entities)
- The State needs to provide a leadership and oversight role. There should be some strong commitment to leadership and oversight and standardization. Some counties do not roll out services in a consistent manner.
- System of Care
- I am concerned about fragmenting the system of care for Older Adults
- Services and reporting to one system of care
- Organizing around funding source fragments and creates silos. We need to think about 5-10-15 years [into the future]. Healthcare reform. I would like to see a Dept. of Health Systems w/ DHCS, ADP, DMH "not merging" but coming together as systems.
- Blowup the boxes and redesign the boxes w/ funding to cut across horizontally, up & down, and left & right.

What opportunities do you see as a result of the transition at the state level?

Consumers/Family Members/Consumer Advocates

- Think from the heart
- Opportunity to reduce the hospitalization rates by using peer run respite centers
- Expand the concept of wellness and recovery across the system of care. Wellness and recovery can become the baseline for all services.
- Client/Recovery movement cannot lose its momentum. Wellness and recovery's higher standard should be the minimum, raise the standards across the board.
- More people available who can provide info on the services that are available.
- More navigators on the ground, in the community.
- Create a system of referral for people with HIV.

- Opportunity to demonstrate commitment to CA diversity, i.e. ethnic groups, EI, blind, hard of hearing, creating and sustaining community prevention, LGBTQ. Veterans were money will be found to support those specific services
- Create better lines of communication in suggested areas that have been made
- More info on Medical and Dental, Vision. (Statewide budget cuts)
- New programs addressing dual problems where resources can be used across both conditions
- To improve access by reducing criteria for eligibility to services.
- Better / more services that will help consumer find appropriate help.
- Eliminate tax breaks from wealthy corporation's and people.
- Opportunity to make it better for our children 10-15 years from now
- Opportunity to develop better and more prevention programs.
- Opportunity for stakeholders to be at final decision making table
- Enforcement of the diagnostic assessment protocol w/ follow up, to ensure the person has a meaningful life.
- WE MUST BE AT THE FINAL DECISION MEETINGS –Nothing About Us Without US. That Means ALL of us.

County Representatives

- Opportunity to develop one cohesive system – basic framework, principle are the same need to combine into one health system
- Educational – get more insight into these other agencies. Will help us move to a more cohesive system and opens up communication
- Work more effectively and efficiently
- Helps for services to be at the county level because we are closer to the people receiving services. We know our demographic and can tailor services
- The responsibilities have to come from resources.
- Concerned about quality of services w/no state level oversight. SB County is the gold standard=) but what about other counties that don't have enough staff?
- Needs to be an awareness of checks and balances. Different practitioners have different need and perspectives. Need a clear understanding priorities and expectations.
- We need a strategic plan to move to one system goals and objectives
- We need to make sure our {behavioral health} needs are met
- There needs to be an education component to help people understanding what they can expect
- Educating the system-people providing services
- There is an assumption that counties have the expertise that is 95% true, but that is not necessarily true about housing. It's a whole different field, level of expertise, etc. County

mental health/behavioral health providers are not housing experts. Serious thought needs to be given to this if these responsibilities are shifted to the local level.

- Housing = for profit venture mental health is about services and supports those two systems are not compatible
- What are the mission and goals of the {proposed} health system?

Providers

- Will the decisions be made by the people [via the Summary Report] or the Legislature? The DMH transition plan will be sent to the Legislature, the final decision will be made there.
- I am trying to reconcile what DMH is responsible for with the functions list. There are 19 functions on the list, are we talking about $2m worth of functions? Is that the task at hand for the 19 staff that will remain?
- The money tied to the functions will also be transferred?
- Southern California is disadvantaged with Northern California continuing to make all the decisions. It should be decentralized, with a focus on equity. The services and resources should go where there is a need.
- We need more equitable distribution of resources and improved regulation.
- Department of Justice into mental health services- there's a huge gap. Many children and adults are sent home only with medications – agencies have to scurry around to get this information – "marry the services" so that DOJ and MH can share information. DOJ should be required to work with DMH. Health Care should be included also.
- Electronic Health Record is very important to ensure continuity of care. Services need to put the client first.

Which entity should assume responsibility for the functions/programs listed? What functions/programs are missing from the list?

County Representatives

- There are some things for which the state has more expertise – housing is one of them. Be cautious about transferring this function locally
- Infuse local level w/experts
- Quality Improvement and Evaluation – the best "policing" is done in-house. We have our own cultures. Improving the system of care should happen at the local level.
- Looking at funding, we could put fed at risk if we don't have a statewide standard measurement system there has to be consistency of care.
- We need a consistent forward movement. We need to include programs people in evaluation.
- Evaluation/QI – data collection and reporting systems that function should be managed in <u>one place.</u>
- Make data more accessible ADP does a great breakdown for <u>every</u> county. They do the work for me.

- When it comes to data & QI it can be difficult to do that locally b/c we are too close to the action or we don't see the flaws or cover-ups
- It should be a collaborative process that includes state and local
- Inspector general model a third party at state or local level can provide cohesiveness
- We want support from the state but we also want local control of QI/Program Eval.
- State can provide education and technical assistance.
- Federal grant programs (PATH, SAMHSA) – I don't see how these can be managed at the local level.
- It's about what is going to keep the money flowing
- The process needs to be integrated and statewide.
- What's wrong w/ what DMH has been providing?
- EMHI-State oversight and administration to prevent misuse of MH funds
- Caregiver Resource Centers should be moved to CDA to avoid duplication of services just have one system. CDA already has funding mechanisms.
- Keep together Medi-Cal, MHSA etc…
- Merge ADP/DMH to eliminate fragmentation, simplify. One audit, one system.
- WET can go to CalMHSA = not all WET programs receive "statewideness" currently no reporting requirements regarding state work/stipends.
- Retain SP/SMHI/Stigma under CalMHSA.
- Merging with DHCS/Medicaid may lose MH parity.
- May move away from recovery to medical model.
- Merging AOD/DMH = should emphasize the MH guidelines; leadership should know about recovery, etc.
- Educate the rest of DHCS
- Mental health usually gets "swallowed up" in general medical system; merging with DHCS = we need to make sure they are fully integrated into the systems. Don't let MH get lost in the system. There is already stigma of mental health in the system.
- There must be built in MH parity in services.
- Billing for MH/AOD services = make it easier for MH + AOD + Medical services.
- CiMH has done a good job with training = keep their contract no matter where their contracts land.
- Housing should be a local program only, takeout the middleman. HUD is only partner.
- For Disaster services, local county deals directly w/Red Cross/FEMA. Multi-county disaster may require state assistance.
- One audit for all, by people with MH expertise.
- Worried about fragmentation if functions go to multiple agencies.
- Only report/collect data if the data is used
- Data should be standardized between each county (data dictionary etc…)
- Go to MHSOAC for outcomes reporting
- Above all, data should be centralized and accessed at one place.

Please note: Stakeholder questions appear in black font, DMH response indicated in red font.

- NON-REVOKABLE PAROLEES = go to probation office
- Co-occurring disorders local but more DHCS
- Concern: If there will be no DMH, will its remaining functions get lost w/in the larger medical system? Where's the leadership?
- Office of Multicultural Services: DHCS, but keep it MH specific

Providers

- Do not continue to bifurcate funding and services.
- Do not allow mental health and substance use disorders to become the "step children" in the public health system
- Create a new department: Health and Behavioral Health Systems
- The challenge is still with stigma of mental illness
- Provide broad education to health providers to increase awareness and understanding of mental health issues. The best place to house this education system is DHCS. We also need to consider this at the local level.
- DHCS will have Medi-Cal, if you start splintering functions, you will not have cohesiveness.
- The MHSOAC is putting the evaluation piece together.
- If the money goes to the locals, who is going to have oversight of the counties (besides the Board of Supervisors)?
- If the functions go to different departments, it will cause fragmentation/splintering of services, and more administrative requirements/expenses.
- Quality improvement/outcomes should go under DHCS.
- We should be talking about efficiencies.
- We want mental health to have equal "footing" with physical health.
- We need a one stop shop for MH, AOD, and PCP. We have to be able to bill for more than one service in a day.
- Not all counties have large military populations (for Veteran's services), resources should go to both locals and State DMH
- Workforce should go to DHCS, contract out when appropriate.
- We need to get rid of silos and "blow up the boxes"
- We should merge all of the functions under one umbrella
- We need strong leadership.

Break-Out Themes

- One cohesive, comprehensive system of care w/health mental health and alcohol and drug programs unified goals/principles
- Educational component and strategic plan to make it clear
- Local Autonomy – recognizing uniqueness of 58 counties
- Responsibilities AND Resources
- Quality of Care: Focus
- Meet the needs of consumers
- Reduce fragmentation and increase efficiency

- Mental health and alcohol and drug programs need clout, cannot lose focus on Recovery by falling back to medical model
- Standardized data collection and reporting
- Continuity of services and oversight
- Opportunity to reduce hospitalization rates
- Expand wellness and recovery across the system of care
- Make time to educate people before we ask for input, we need more navigators
- Improved referral system
- Commitment to cultural competence – racial/ethnic communities
- Veterans
- Need to know how much money/Resources is available with the functions
- Whole person approach
- Look at eligibility requirements
- Eliminate tax breaks for corporations
- Increased opportunity for children
- Include Stakeholders at FINAL Decision-making table
- Strong leadership
- Outcome based incentives

What do you believe are the challenges associated with the changes to mental health at the state level? How can these challenges be addressed?

- We have a lot of people into power and control. [Resources] are spread out. What can we do to improve collaboration and sharing? San Bernardino is a model
- It's not about saving jobs - it's about services.
- Don't move ahead too quickly. Push for mental health leadership. Do what is right because it's the right thing. Don't be intimated due to lack of resources. Be courageous!
- Our biggest challenge is going to be our own fears of change. The people needing services (not jobs) is the #1 priority
- Inclusion and collaboration promote organizational health
- Consumers and providers need to continue to be at the table. Let providers share what they think w/o fear of retribution oversight and accountability
- Reporting transparency

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